

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12532

13768

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| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | c. LENGTH OF STAY IN 1b 7 mos. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Reuben Middle - Last Baumgartner | | 4. DATE OF DEATH Month November Day 23 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 17, 1879 |
| 9. AGE (In years lost birthday) 81 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Baumgartner | | 14. MOTHER'S MAIDEN NAME Anna Hefty | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unk. - | | 16. SOCIAL SECURITY NO. 214-03-6300 | |
| 17. INFORMANT RECORDS: Eastern Shore State Hospital | | Address | |

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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) General Arteriosclerosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

21. I certify that (I) (this hospital) attended the deceased from **April 23, 1960** to **Nov. 23, 1960**, that (I) (we) last saw the deceased alive on **Nov. 22, 1960**, and that death occurred at **12:55 AM** from the causes and on the date stated above.

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| 22a. SIGNATURE E. De Filippis | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type) E. DeFilippis | | 22d. ADDRESS Eastern Shore State Hospital, Cambridge, Md. |

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11/25/60 | 23c. NAME OF CEMETERY OR CREMATORY East New Market | 23d. LOCATION (City, town, or county) (State) East New Market Md |
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| 24. FUNERAL DIRECTOR'S SIGNATURE Keith S. Halloway | ADDRESS East New Market, Md | 25a. REC'D BY REGISTRAR DATE DEC 13 '60 | 25b. REGISTRAR'S SIGNATURE Arthur S. Smith |
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10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12518
CERTIFICATE OF DEATH

12495

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | c. LENGTH OF STAY IN 1b 19 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Margaret Middle Slacum Last Banks | | 4. DATE OF DEATH Month November Day 6 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 14, 1901 |
| 9. AGE (In years last birthday) 59 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) East New Market, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Noah Slacum | | 14. MOTHER'S MAIDEN NAME Sarah Young | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213-14-6976 | |
| 17. INFORMANT Mrs. Roland Jackson, East New Market, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 1, 1960 to November 6, 1960 , that (I) (we) last saw the deceased alive on Nov. 6, 1960 , and that death occurred at 12 Noon from the causes and on the date stated above. | | | |
| 22a. SIGNATURE J. Edwin Fassett | | 22b. DATE 11-8-60 | |
| 22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D. | | 22d. ADDRESS 227 Pine St-Cambridge, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 10, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery | | 23d. LOCATION (City, town, or county) (State) East New Market, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland | | 25a. REC'D BY REGISTRAR NOV 14 60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Thaw | | | |

15195

CERTIFICATE OF DEATH

15195



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

12516
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12496

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | c. LENGTH OF STAY IN 1b 4 Mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linkwood Rural | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital D.O.A. | | | | d. STREET ADDRESS R.F.D. 15 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Julia Ann Beasley | | | | 4. DATE OF DEATH Nov. 15 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July, 8, 1960 | | 9. AGE (In years last birthday) 47 yrs. | IF UNDER 1 YEAR Months 4 Days 7 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Jones | | | | 14. MOTHER'S MAIDEN NAME Salley Mae Beasley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Walter Jones Linkwood, Md. Rt. 15 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute respiratory infection DUE TO (c) Malnutrition | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 4 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Mace Jr. M.D. | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 11/16/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/16/60 | | 22c. NAME OF CEMETERY OR CREMATORY Salem Cemetery | | 22d. LOCATION (City, town, or country) (State) Salem, Dorchester, Md. | |
| 23. FUNERAL DIRECTOR Walter Jones | | | | ADDRESS Linkwood, Md. | | 24e. REC'D BY REGISTRAR NOV 17 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hanna | | | |

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18116
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF NEW YORK
DEPARTMENT OF HEALTH

FOR DEATH
CERTIFICATE

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Signature of Medical Examiner: _____

8. Signature of Coroner: _____

9. Signature of Registrar: _____

10. Signature of Physician: _____

11. Signature of Nurse: _____

12. Signature of Undertaker: _____

13. Signature of Burial: _____

14. Signature of Cremation: _____

15. Signature of Other: _____

16. Signature of _____

17. Signature of _____

18. Signature of _____

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please make the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|--|---|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 12517 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co. | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland. | | | | | c. LENGTH OF STAY IN 1b 8 Days | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glasgow Nursing Home | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Matilda Elizabeth Bell | | | | | 4. DATE OF DEATH Month 11 Day 28 Year 19 60 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/2/1872 | | 9. AGE (In years last birthday) 88 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | IF UNDER 1 YEAR Months Days Hours Min. | | | | | | |
| 13. FATHER'S NAME Levin James Spicer | | | | | 14. MOTHER'S MAIDEN NAME Anette Keene | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | | | | 16. SOCIAL SECURITY NO. No | | | | | 17. INFORMANT Mr. Spicer Bell, Tablot Ave, Cambridge, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 904.0 (c) 904.0 | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| Fracture of neck right femur. | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell in home | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 8 P.M. 11/6/60 | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Home | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | | | | 20f. (City or town) (County) (State) Cambridge, Dor. Md. | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John Mace Jr.</i> | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| EXAMINER'S NAME (Type) John Mace Jr. M.D. | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/29/60 | | | | | | | | | |
| | | | | | Address (Street, city, town, or county) | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/30/1960 | | 22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park | | 22d. LOCATION (City, town, or country) (State) Cambridge, Maryland | | | | | | | | |
| 23. FUNERAL DIRECTOR Le Comptz Funeral Service, Cambridge, Maryland | | | | | 24a. REC'D BY REGISTRAR DEC 9 '60 | | | | | | | | | |
| | | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i> | | | | | | | | | |

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DEC 9 '60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12533 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12497

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md. R.F.D.# 3, 9 Months</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge, Maryland. R.F.D.# 3,</u> | | | | 2. USUAL RESIDENCE (Where decedent lived, If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland. R.F.D.# 3,</u> d. STREET ADDRESS <u>None</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mary Catherine Jackson Brinsfield</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1960</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/22/1889</u> | | | |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Dorchester, Co. Maryland.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Samuel Jackson</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Jackson</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | | |
| 17. INFORMANT <u>Mr. Samuel Brinsfield, R.F.D.# 3, Cambridge, Md.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>420.1</u> (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input type="checkbox"/>. and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John Mace Jr.</u> | | EXAMINER'S NAME (Type) <u>John Mace Jr.</u> | | DATE SIGNED <u>11/18/60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11/20/1960.</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u> | | | |
| 22d. LOCATION (City, town, or country) (State) <u>Cambridge Maryland.</u> | | 23. FUNERAL DIRECTOR ADDRESS <u>Le Compte Funeral Service, Cambridge, Maryland,</u> | | | | | |
| 24a. REC'D BY REGISTRAR <u>NOV 23 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>C. L. S. Frank</u> | | | | | |

Location, Co. ...
Date, ...
Time, ...

Gender, ...
Age, ...
Race, ...

Marital Status, ...
Occupation, ...
Residence, ...

Cause of Death, ...
Manner of Death, ...
Place of Death, ...

Signature of Medical Examiner, ...
Signature of Coroner, ...
Signature of Registrar, ...

Witness, ...
Date, ...
Time, ...

Signature of Medical Examiner, ...
Signature of Coroner, ...
Signature of Registrar, ...

Witness, ...
Date, ...
Time, ...

Signature of Medical Examiner, ...
Signature of Coroner, ...
Signature of Registrar, ...

Witness, ...
Date, ...
Time, ...

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

12534 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12498

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | c. LENGTH OF STAY IN 1b <u>2 mos. 26 days</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | d. STREET ADDRESS <u>Route 5</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>M.</u> Last <u>Bullock</u> | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 11, 1895</u> | |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Mills</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A. Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Miller Bullock</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SARAH HALL</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>222-03-4011</u> | | 17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> 904.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture 11th. rib. R.</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>79 days</u> | | | | | | | |
| 20a. EXT. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found lying on floor</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9-10-</u> <u>60</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u> | | 20f. (City or town) (County) (State) <u>Cambridge Dor. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John Mace Jr.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>John Mace Jr.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED <u>11/28/60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11-30-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist</u> | | 22d. LOCATION (City, town, or country) (State) <u>Elkton R.D. Cecil Md</u> | |
| 23. FUNERAL DIRECTOR <u>Joseph A. Law NorthEast Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 1 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

1

WILLIAM B. MILLER DAVID H. MILLER

Residence: New York City

General Superintendent

Young Men's Christian Association

2-11-60

[Signature]

John A. Miller

DO NOT WRITE IN THESE SPACES

12519

CERTIFICATE OF DEATH

12499

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital | | | | e. STREET ADDRESS RFD #2 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle (Willie) Last Burrows | | | | 4. DATE OF DEATH Month Nov. Day 26 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 15, 1901 | | 9. AGE (In years last birthday) 59 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Dorchester Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Burrows | | | | 14. MOTHER'S MAIDEN NAME Ellen Burrows | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-30-1239 | | 17. INFORMANT Bell Burrows, RFD 2, Cambridge, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum with metastasis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from May 10, 1960 , to Nov 26, 1960 , that I last saw the deceased alive on November 26, 1960 , and that death occurred at 8 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE [Signature] M.D. 227 Pine St-Cambridge, Md. 11-29-60 PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/30/1960 | | 22c. NAME OF CEMETERY OR CREMATORY Aireys Cemetery | | 22d. LOCATION (City, town, or county) _____ (State) _____ Dorchester County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Cambridge, Md. | | | | 24a. REC'D BY REGISTRAR DEC 7 '60 | | 24b. REGISTRAR'S SIGNATURE [Signature] | |

CERTIFICATE OF DEATH

15219

MASSACHUSETTS DEPARTMENT OF HEALTH-BATH-ORE 18

1918

| | | | |
|---------------------------------------|--|--|--|
| NAME OF DECEASED George Smith | | DATE OF DEATH Jan 15, 1918 | |
| AGE 45 | | SEX Male | |
| BIRTH Jan 1, 1873 | | PLACE OF BIRTH Boston, Mass. | |
| OCCUPATION Carpenter | | CAUSE OF DEATH Heart Disease | |
| MANNER OF DEATH Natural | | SIGNATURE OF PHYSICIAN J. H. Smith | |
| SIGNATURE OF DECEASED George Smith | | SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones | |
| LOCALITY Boston, Mass. | | COUNTY Suffolk | |
| STATE Massachusetts | | REGISTRATION NO. 15219 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G276 12-2-60 et

CERTIFICATE OF DEATH

12500

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island | |
| 3. NAME OF DECEASED (Type or print) First William Middle T Last Cornish | | 4. DATE OF DEATH Month Nov. Day 15, Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1866 April 1, 1886 |
| 9. AGE (In years last birthday) 94 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Laborer | |
| 11. BIRTHPLACE (State or foreign country) Dorchester Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Travers | | 14. MOTHER'S MAIDEN NAME Mary P. Cornish | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Naomi Tilghman, Taylors Island, Md. | |
| 17. INFORMANT Naomi Tilghman, Taylors Island, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 2, 1959 , to November 15, 1960 , that I last saw the deceased alive on November 15, 1960 , and that death occurred at 10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED 11-19-60 ACTUAL SIGNATURE J. Edwin Fassett M.D. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11/20/1960 | 22c. NAME OF CEMETERY OR CREMATORY Taylors Island | 22d. LOCATION (City, town, or county) (State) Taylors Island, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert M. St. Louis ADDRESS Cambridge, Md. | | 24a. REC'D BY REGISTRAR DATE NOV 28 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

225

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12520

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12501

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transfer permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

| | | | | | |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | c. LENGTH OF STAY IN 1b <u>25 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u> | | | d. STREET ADDRESS <u>9 Cross Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Downes</u> Last <u>Downes</u> | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1960</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 1, 1905</u> | | 9. AGE (in years last birthday) <u>55</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13. FATHER'S NAME <u>Stephen Teat</u> | | | 14. MOTHER'S MAIDEN NAME <u>Blanche Downes</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-10-6132</u> | | 17. INFORMANT Address <u>Pauline Downes, Cambridge, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY EMBOLUS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>o. m. p. m.</u> <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>ALFRED R. MARYANOV</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11/23/1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u> | |
| | | | | 22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Sellaue Jr.</u> | | ADDRESS <u>Cambridge, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12536

13781

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island, Maryland. Life | | | | c. LENGTH OF STAY IN 1b X Taylors Island, Maryland. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home | | | | d. STREET ADDRESS None | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First James Middle A. Last Geohagan | | | | 4. DATE OF DEATH Month 11 Day 22 Year 19 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/18/1864 | 9. AGE (In years last birthday) 96 yrs. | 10. IF UNDER 1 YEAR: Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | 10b. KIND OF BUSINESS OR INDUSTRY Ship- Carpenter | | 11. BIRTHPLACE (State or foreign country) Dorchester, Co. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Moses Geohagan | | | | 14. MOTHER'S MAIDEN NAME Jane Wallace | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Mrs. Irving Hosreman, 3614 Seventh, St. Brooklyn, 25, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary Heart Disease DUE TO (c) 10yrs INTERVAL BETWEEN ONSET AND DEATH 2 months | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/30/60 to 11/22 19 60 , that (I) (we) last saw the deceased alive on 9/30 19 60 , and that death occurred at 11/22 from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Lawrence Maryanov | | | | 22b. DATE SIGNED 11/25/60 | | 22c. PHYSICIAN'S NAME (Type) Lawrence Maryanov | |
| 22d. ADDRESS 136 Race St Cambridge, Md | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/25/1960. | | 23c. NAME OF CEMETERY OR CREMATORY Brick Church Yard. | | 23d. LOCATION (City, town, or county) (State) Taylors Island, Maryland. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland. | | | | 25a. REC'D BY REGISTRAR DEC 9 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kline | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12503

12521

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|---|------------------------------|--|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u> | | c. LENGTH OF STAY IN 1b <u>1 yr</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLAYGOW NURSING HOME</u> | | | | d. STREET ADDRESS <u>05X-2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>EUGENIA</u> Last <u>HITCHENS</u> | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>1960</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN 31, 1875</u> | 9. AGE (In years last birthday) <u>85</u> yrs. | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOSEPH N. LE COMPTE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SARAH V. HURLEY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>J. Howard LeCompte</u> | | Address <u>Cambridge</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rt. hemiplegia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension - arteriosclerotic CVD</u> DUE TO (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart failure terminal</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 19, 1958</u> , to <u>Nov 17, 1960</u> , that I last saw the deceased alive on <u>Nov 19, 1960</u> , and that death occurred at <u>1000</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. W. Thompson</u> | | | | ADDRESS (Street, city or town, state) <u>Cambridge, Md</u> | | | |
| DATE SIGNED <u>11/19/60</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>J. W. Thompson</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov 19, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u> | | 22d. LOCATION (City, town, or county) (State) <u>Denton Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Thompson</u> | | | | ADDRESS <u>Denton, Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>NOV 22 60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

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12522

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12504

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| 1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland. | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 607 Race, Street. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Minnie Middle Wiley Last Hughes | | 4. DATE OF DEATH Month 11 Day 8 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/30/1888 |
| 9. AGE (In years last birthday) 71 yrs. | | 10. IF UNDER 1 YEAR Months 11 Days 8 Hours 19 Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 12. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 13. FATHER'S NAME Daniel J. Wiley | | 14. MOTHER'S MAIDEN NAME Bertie Wiley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Mr. Arthur Hughes, 607 Race, St. Cambridge, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 26 hours | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11/8 19 60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/8 19 60 to 11/8 19 60 , that (I) (we) last saw the deceased alive on 11/8 19 60 , and that death occurred at 8 P M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE W. H. Hanks | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) W. H. Hanks | | 22d. ADDRESS CAMBRIDGE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/10/1960. | |
| 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, | | 23d. LOCATION (City, town, or county) (State) Cambridge, Maryland. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland. | | 25a. REC'D BY REGISTRAR NOV 16 '60 | |
| 25b. REGISTRAR'S SIGNATURE Clifton L. Kline | | 25c. DATE NOV 16 '60 | |

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1882

NAME OF DECEASED
RESIDENCE
AGE
SEX
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR

Handwritten notes and signatures, including a large signature in the center and various dates and names at the bottom.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12537

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12505

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|---|-------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>DORCHESTER</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> <u>Delmar</u> | | c. LENGTH OF STAY IN 1b <u>Since 9/14/1955</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Eastern Shore State Hospital</u> | | d. STREET ADDRESS <u>Unknown</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JDA</u> Middle <u>JORDAN</u> Last <u>JORDAN</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1960</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1886</u> About <u>74</u> yrs. |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Hospital Record</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration.</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Sever. yrs.</u> <u>Sever. yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/14</u> <u>1955</u> to <u>11/6</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>Novem. 6</u> <u>1960</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Simon Virku</u> | | 22b. DATE SIGNED <u>Novem. 6, 1960</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Simon Virku</u> | | 22d. ADDRESS <u>Eastern Shore State Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>11/9/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>MT. SALEM</u> | | 23d. LOCATION (City, town, or county) (State) <u>WILMINGTON DE</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>LECOMPT FURNAL SER. CAMBRIDGE MD</u> | | 25a. REC'D BY REGISTRAR <u>NOV 9 '60</u> | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

1897

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1897

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12538

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12506

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | c. LENGTH OF STAY IN 1b 11mo. 7 das. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro Rural | | d. STREET ADDRESS - None | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Roy Middle - Last Kemp | | 4. DATE OF DEATH Month November Day 15 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 9, 1903 |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR Months 5 Days 15 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Bob Kemp | | 14. MOTHER'S MAIDEN NAME Cora ? Bell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No? | | 16. SOCIAL SECURITY NO. 221-10-6566 | |
| 17. INFORMANT RECORDS - Eastern Shore State Hospital | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 443X DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from December 8 1959 to November 15 1960 , that (I) (we) last saw the deceased alive on Nov. 15 1960 , and that death occurred at 4 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE E. DeFilippis | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. E. DeFilippis | | 22d. ADDRESS E.S.S. Hospital, Cambridge, Md. 11-15-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-18-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive | | 23d. LOCATION (City, town, or county) (State) Sandtown, Delaware | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais Greensboro, Md. | | 25a. REC'D BY REGISTRAR DATE NOV 17 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Huns | | | |

15706

CERTIFICATE OF DEATH

15706

MARYLAND STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS

NAME OF DECEASED

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature

Signature

Signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12539
CERTIFICATE OF DEATH

12507

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|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE | | c. LENGTH OF STAY IN 1b 4 YEARS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First NORA Middle VIRGINIA Last LAMBDIN | | 4. DATE OF DEATH Month NOV. Day 8 Year 1960. | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 20, 1874 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS BALL | | 14. MOTHER'S MAIDEN NAME MARY HARRISON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT HOSPITAL RECORD | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERAL ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JUNE 1, 1957 , to NOV. 8, 1960 ; that (I) (we) last saw the deceased alive on NOV. 8, 1960 , and that death occurred at 10:07 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Ettore De Filippis | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) ETTORE DEFILIPPIS | | 22d. ADDRESS EASTERN SHORE STATE HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Harrison | | 25a. REC'D BY REGISTRAR me | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Harrison | | 25c. DATE NOV 14 '60 | |

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12508

12540

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|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural | | c. LENGTH OF STAY IN lb Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reliance | | | | d. STREET ADDRESS Reliance | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Henry Last Lankford | | | | 4. DATE OF DEATH Month November Day 27 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 31, 1876 | | 9. AGE (In years last birthday) 84 yrs. | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Martin V. Lankford | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Cannon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-12-1098 | | 17. INFORMANT Mrs. Ida O. Lankford, Seaford, Del., R.F.D. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Cerebral thrombosis with hemiplegia | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs 3 yrs 10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis with hemiplegia | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 1957 to Nov 27, 1960 , that (I) (we) last saw the deceased alive on Nov 26, 1960 , and that death occurred 12:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE J. J. Frampton | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 4/25/61 | |
| 22c. PHYSICIAN'S NAME (Type) J. J. FRAMPTON M.D. | | | | 22d. ADDRESS 301 Palatka Seaford Del | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 29, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery | | 23d. LOCATION (City, town, or county) _____ (State) _____ Near Federalsburg, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland | | | | 25a. REC'D BY REGISTRAR DATE DEC 2 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MEDICAL CERTIFICATION

13540

CERTIFICATE OF DEATH

MADE BY THE STATE OF CALIFORNIA
IN THE COUNTY OF LOS ANGELES

13540

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
EDUCATION
MARRIAGE
RELIGION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF DECEASED
SIGNATURE OF WITNESSES
SIGNATURE OF MINISTER
SIGNATURE OF JUDGE
SIGNATURE OF CLERK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12541

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12509

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|--|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | c. LENGTH OF STAY IN 1b 7 mos. 4 das | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital | | d. STREET ADDRESS - 200 BROCKLETTS AVE | |
| 3. NAME OF DECEASED (Type or print) First Eva Middle Belle Last Marvel | | 4. DATE OF DEATH Month November Day 29 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-1-75 |
| 9. AGE (In years lost birthday) 85 yrs. | | IF UNDER 1 YEAR Months 20 Days 4 Hours 2 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- | | 10b. KIND OF BUSINESS OR INDUSTRY -- | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Landon, Maryland | | 14. MOTHER'S MAIDEN NAME Sophia Ellen Ford, Maryland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- | | 16. SOCIAL SECURITY NO. -- | |
| 17. INFORMANT Eastern Shore State Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation on 11-16-60: Incision and drainage of large abscess overlying right greater trochanteric | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-25-60 to 11-29-60 , that (I) (we) lost the deceased on 11-29-60 and that death occurred at 3:45pm from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Ettore DeFilippis | | 22b. DATE SIGNED 11-29-60 | |
| 22c. PHYSICIAN'S NAME (Type) Ettore DeFilippis, M.D. | | 22d. ADDRESS Eastern Shore State Hospital Cambridge, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Dec 7, 1960 | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY Spring Hill | | 23d. LOCATION (City, town, or county) (State) Easton MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus | | 25a. REC'D BY REGISTRAR DEC 2 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the office of the Medical Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12542 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12510

| | | | | |
|---|----------------------------------|--|------------------------------------|---|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN lb 8 Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E.S.S. Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Edgar Ryland Pennington | | 4. DATE OF DEATH Month Day Year Nov. 11 19 60 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/24/75 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME William Pennington | | 14. MOTHER'S MAIDEN NAME --- Kelly | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. 213-24-1046 | | |
| 17. INFORMANT Records E.S.S. Hospital. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture clavicle | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> Fell out of bed | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3 -30 19 60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Living Home | | 20f. (City or town) (County) (State) Kennedyville Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) John Mace Jr. M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/11/60 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11-14-60 | | |
| 22c. NAME OF CEMETERY OR CREMATORY STILL POND CEM'TY | | 22d. LOCATION (City, town, or country) (State) STILL POND, MD. | | |
| 23. FUNERAL DIRECTOR Victor N. Kennedy ADDRESS STILL POND, MD | | 24a. REC'D BY REGISTRAR DATE NOV 14 '60 | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. House | | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12511

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural | | c. LENGTH OF STAY IN 1b Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. #1 | | | | d. STREET ADDRESS R.F.D. #1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Magdalene Last Pennington | | | | 4. DATE OF DEATH Month November Day 5 Year 19 60 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 21, 1911 | |
| 9. AGE (In years last birthday) 49 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 | | IF UNDER 24 HRS. Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Vienna, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Alexander Jackson | | | | 14. MOTHER'S MAIDEN NAME Henrietta Stewart | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213-14-7717 | | 17. INFORMANT Johnnie Pennington, Vienna, Maryland, RFD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 min. | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE John Mace Jr. M.D. | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John Mace Jr. M.D. | | | | DATE SIGNED 11/8/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Nov. 8, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery | | 22d. LOCATION (City, town, or county) (State) Vienna, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland | | | | 24a. REC'D BY REGISTRAR Nov 8 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12544

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12512

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|---|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own home, no street numbers, Rural | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Edward Franklin Perry, Sr. | | | | 4. DATE OF DEATH Month November Day 5th. Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1890 | 9. AGE (In years last birthday) 70 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Shipyard worker | | 10b. KIND OF BUSINESS OR INDUSTRY Ship Bldg. & Repr. | | 11. BIRTHPLACE (State or foreign country) Middlesex Co. Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Albert Perry | | | | 14. MOTHER'S MAIDEN NAME Clarice Trader | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. 218-05-3511 | | 17. INFORMANT 2513 So. Deane Ave. E.F. Perry, Jr. Baltimore, 30 Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute pulmonary oedema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial occlusion DUE TO (c) Arteriosclerotic cardio-vascular disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Eldridge H. Wolff | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 11/6/60 | |
| EXAMINER'S NAME (Type) Eldridge H. Wolff, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/8/60 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John F. Denny, Inc. Baltimore, Maryland | | | | 24a. REC'D BY REGISTRAR NOV 9 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

12523

CERTIFICATE OF DEATH

Reg. Dist. No. 13801

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | | | c. LENGTH OF STAY IN 1b 12 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | f. STREET ADDRESS 121 A Race St., | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle Meyers Last Phillips | | | | 4. DATE OF DEATH Month November Day 26 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 8, 1905 | |
| 9. AGE (In years last birthday) 55 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Lewis Meyers | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Mr. Floyd Phillips, Race St., Cambridge, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery Occlusion 022X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm aorta DUE TO (c) Hypertension | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis (biliary) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 9/20 , 19 60 to 11/26 , 19 60 , that I last saw the deceased alive on 11/26 , 19 60 , and that death occurred at 11:30 AM from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) 104 LOCUST ST Cambridge, Md. | | | | | | | |
| ACTUAL SIGNATURE W. H. Hanks M.D. 12/1/60 | | | | | | | |
| PHYSICIAN'S NAME (Type) W. H. Hanks CAMBRIDGE, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF November 28, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery | | 22d. LOCATION (City, town, or county) (State) Cambridge, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas | | | | 24a. REC'D BY REGISTRAR DEC 8 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

12345

1080

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurring and bleed-through.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12524

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12513

| | | | |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland | | c. LENGTH OF STAY IN 1b 3 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Goldsborough Middle Phillips Last Phillips | | 4. DATE OF DEATH Month 11 Day 5 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/15/1892 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | 10b. KIND OF BUSINESS OR INDUSTRY Waterman | |
| 11. BIRTHPLACE (State or foreign country) Toddville, Maryland. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Soloman Phillips | | 14. MOTHER'S MAIDEN NAME Susie A. Moore | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-10-6849 | |
| 17. INFORMANT Mrs. O'Neill Jones, Toddville, Maryland. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma DUE TO Adenocarcinoma Ascending Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 months DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/20 19 60 to 11/5 19 60 , that (I) (we) last saw the deceased alive on 11/5 19 60 , and that death occurred at 4 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE W. H. Hanks | | 22b. DATE SIGNED 11/7/60 | |
| 22c. PHYSICIAN'S NAME (Type) W. H. HANKS, M.D. | | 22d. ADDRESS CAMBRIDGE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/8/1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park | | 23d. LOCATION (City, town, or county) (State) Cambridge, Maryland. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland. | | 25a. REC'D BY REGISTRAR NOV 9 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hanks | | | |

12525

CERTIFICATE OF DEATH

12514

Reg. Dist. No.

| | | | |
|---|------------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | c. LENGTH OF STAY IN 1b 2 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jo Middle Ann Last Sampson | | 4. DATE OF DEATH Month November Day 14 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-12-60 |
| 9. AGE (In years last birthday) yrs. 2 | | IF UNDER 1 YEAR Months 2 Days 9 Hours 45 Min. 45 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Joe Louis Sampson | | 14. MOTHER'S MAIDEN NAME Doretha Leona Travers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Doretha Sampson- 6 Phillips St. Cambridge, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity + Immaturity 776X DUE TO wgt. 1 lb 14 oz Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-12 , 19 60 , to 11-14 , 19 60 , that I last saw the deceased alive on 11-14-60 , 19 60 , and that death occurred at 11:38 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Eldridge H. Wolff M.D. | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) Dr. Eldridge H. Wolff | | 15 Locust St. Cambridge | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-15-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Private | | 22d. LOCATION (City, town, or county) (State) Cambridge Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joe Louis Sampson | | 24a. REC'D BY REGISTRAR NOV 18 '60 | |
| ADDRESS 2067 206XV0 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAY 21 1960
11/28/60
DEC 9 '60

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Dorchester, Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. R.F.D.# 3 | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Lloyd Middle Edmonds Last Seward | | | | 4. DATE OF DEATH Month 11 Day 25 Year 19 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/20/1885 | | 9. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farmer | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James A. Seward | | | | 14. MOTHER'S MAIDEN NAME Ella Todd | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Mrs. Lloyd Seward, R.F.D.#3 Cambridge, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Manth, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 21, 1956 to Nov 24, 1960 , that (I) (we) last saw the deceased alive on Nov 19, 1960 , and that death occurred at 10:30 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Alfred R. Maryanov | | | | 22b. DATE SIGNED 11/28/60 | | 22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV | |
| 22d. ADDRESS 136 RACE ST. CAMBRIDGE, MD. | | | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/27/1960 | | 23c. NAME OF CEMETERY OR CREMATORY Speddens Cemetery | | 23d. LOCATION (City, town, or county) (State) Cambridge, Md. R.F.D # 3 | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland. | | | | 25a. REC'D BY REGISTRAR DEC 9 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

1000

504-505

• *continued*

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CONFIDENTIAL

0-987654-3210

15

Estimate σ^2 = $\frac{1}{n-1} \sum_{i=1}^n (x_i - \bar{x})^2$

24

5881/3546

et al.

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[illegible]

00911551-2

12526

CERTIFICATE OF DEATH

12515

Reg. Dist. No.

| | | | | | |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Sorchester</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Sorchester</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Hospital</u> | | | d. STREET ADDRESS <u>R7W-1-</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>Carlton Matthews</u> | | | 4. DATE OF DEATH <u>Nov-6-1960</u> | | |
| 5. SEX <u>Male</u> | | | 6. COLOR OR RACE <u>White</u> | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <u>Sept 19-1887</u> | | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | |
| 13. FATHER'S NAME <u>Charles M. Slagle</u> | | | 14. MOTHER'S MAIDEN NAME <u>Sachal A. Matthews</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>no</u> | | |
| 17. INFORMANT <u>Carlton Matthews</u> | | | Address <u>Easton Md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>274X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>?</u> <u>10 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcohol, simple</u> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>1952</u> to <u>1960</u> that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>60</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>W. Thompson</u> M.D. | | | ADDRESS (Street, city or town, state) <u>Cambridge Md</u> | | |
| PHYSICIAN'S NAME (Type) <u>J. A. Thompson</u> | | | DATE SIGNED <u>11/6/60</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | | 22b. DATE THEREOF <u>11/9/60</u> | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u> | | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Morris</u> | | | ADDRESS <u>Baltimore Md</u> | | |
| 24a. REC'D BY REGISTRAR | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | |
| DATE <u>NOV 9 '60</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12516

12527

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|---|--|--------------------------|
| 1. PLACE OF DEATH o. COUNTY Dorchester, Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester, Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland. | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 702 Race, Street. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Alice Middle Phillips Last Smith | | | | 4. DATE OF DEATH Month 11 Day 16 Year 19 60 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/26/1898 | | 9. AGE (In years lost birthday) 62 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edwards Phillips | | | | 14. MOTHER'S MAIDEN NAME Sarah Mills | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Yes | | 17. INFORMANT Address Mr. Emmett V. Smith, 802 Race, St. Cambridge, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. } (b) Coronary Heart Disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 15 min 1 1/2 yrs | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 11/9 1960 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/11/60 to 11/16, 1960 , that (I) (we) last saw the deceased alive on 11/9 1960 , and that death occurred on 11/16 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Lawrence Maryanov | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11/17/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) Lawrence Maryanov | | 22d. ADDRESS 136 Race St Cambridge, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/18/1960. | | 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park | | 23d. LOCATION (City, town, or county) (State) Cambridge, Maryland. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland. | | | | 25a. REC'D BY REGISTRAR NOV 23 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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• **Journal of the American Medical Association**

4. *Journal of the American Statistical Association*, 92, 1997, 1033-1042.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12546

12517

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Estella Middle Gertrude Last Stafford | | | | 4. DATE OF DEATH Month Nov. Day 14 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 5, 1898 | | 9. AGE (In years last birthday) 61 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Dorchester Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jehremiah Mc Cready | | | | 14. MOTHER'S MAIDEN NAME Florence E. Ennells | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Joseph Stafford, RFD 3, Cambridge, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr 11 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/8 , 19 60 , to 11/14 , 19 60 ; that I last saw the deceased alive on 11/14 , 19 60 , and that death occurred at 10:10 P. M. from the causes and on the date stated above. | | | | | | | DATE SIGNED 11/18/60 |
| ACTUAL SIGNATURE Lawrence Maryanov | | | | ADDRESS (Street, city or town, state) 136 Race St. | | DATE SIGNED 11/18/60 | |
| PHYSICIAN'S NAME (Type) Lawrence Maryanov | | | | Cambridge, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/27/1960 | | 22c. NAME OF CEMETERY OR CREMATORY Linus Road | | 22d. LOCATION (City, town, or county) (State) Dorchester County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hubert M. St. Louis | | | | ADDRESS Cambridge, Md. | | 24a. RECORDING REGISTRAR 10/28/60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |

CERTIFICATE OF DEATH

Reg. Dist. No.

12518

12528

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | | | c. LENGTH OF STAY IN 1b 15 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Louis Middle Ferris Last Tomey | | | | 4. DATE OF DEATH Month November Day 21 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 4, 1907 | |
| 9. AGE (In years last birthday) 53 yrs. | | 10. AGE (In years last birthday) 53 yrs. | | 11. AGE (In years last birthday) 53 yrs. | | 12. AGE (In years last birthday) 53 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bacteriologist | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Almatara, Lebanon | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Ferris B. Tomey | | | | 14. MOTHER'S MAIDEN NAME Mary Sarhas | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 332-18-3845 | | | |
| 17. INFORMANT Mrs. Evelyn S. Tomey | | | | Address 6 High St., Cambridge, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 hours INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11/21 1960 | | | | | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 11/21 1960 to 11/21 1960 , that I last saw the deceased alive on 11/21 1960 , and that death occurred at 3:45 PM from the causes and on the date stated above. | | | | | | | |
| 22. ADDRESS (Street, city or town, state) 104 Locust St. Cambridge Md | | | | | | | |
| 23. DATE SIGNED 11/23/60 | | | | | | | |
| ACTUAL SIGNATURE W. H. Hanks | | | | | | | |
| PHYSICIAN'S NAME (Type) W. H. Hanks | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF Nov. 23, 1960 | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery | | | | | | | |
| 22d. LOCATION (City, town, or county) (State) East New Market, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Livorn | | | | | | | |
| ADDRESS Cambridge, Md. | | | | | | | |
| 24a. REC'D BY REGISTRAR NOV 28 '60 | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hanks | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - SALT SPRING, W. VA.
CERTIFICATE OF DEATH
1925

NAME: _____
AGE: _____
SEX: _____
RACE: _____
BIRTH: _____
DEATH: _____
PLACE OF BIRTH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF PHYSICIAN: _____
SIGNATURE OF WITNESS: _____
DATE: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 12529 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 12519 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Dorchester, Co. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland. c. LENGTH OF STAY IN lb 1 Hour d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot, Co. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton, Maryland. d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Virginia T. Webb | | | | | | 4. DATE OF DEATH Month 11 Day 8 Year 1960 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/10/1880 | | 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | | | 11. BIRTHPLACE (State or foreign country) Maryland. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Tubman | | | | | | 14. MOTHER'S MAIDEN NAME Isabelle Stapleforte | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Mrs. Louis Long, Church, Creek, Maryland/ | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial injury DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of skull DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 hrs. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in two car auto collision. | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. 3:45 PM Month, Day, Year 11-8-1960 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) East New Market Dor. Md. | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) John Mace Jr. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/10/60 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 11/11/1960. | | 22c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery | | 22d. LOCATION (City, town, or country) (State) Vienna, Maryland. | | | |
| 23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Maryland. | | | | | | 24a. REC'D BY REGISTRAR DATE NOV 15 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krawe | | | |

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS
BIRTH, DEATH AND MARRIAGE RECORDS
STATE OF NEW YORK



| NAME | DATE OF BIRTH | DATE OF DEATH | PLACE OF BIRTH | PLACE OF DEATH | CAUSE OF DEATH | SEX | AGE | EDUCATION | RELIGION | MARRIAGE | CHILDREN | OTHER |
|-----------------|---------------|---------------|----------------|----------------|----------------|--------|-----|-------------|------------|----------|----------|-------|
| John Doe | 1/1/1900 | 1/1/1900 | New York | New York | Heart Disease | Male | 60 | High School | Protestant | Married | 2 | |
| Jane Smith | 2/2/1901 | 2/2/1901 | New York | New York | Stroke | Female | 55 | High School | Catholic | Married | 3 | |
| Robert Johnson | 3/3/1902 | 3/3/1902 | New York | New York | Pneumonia | Male | 45 | High School | Protestant | Married | 1 | |
| Mary White | 4/4/1903 | 4/4/1903 | New York | New York | Cancer | Female | 50 | High School | Catholic | Married | 2 | |
| Charles Brown | 5/5/1904 | 5/5/1904 | New York | New York | Heart Disease | Male | 65 | High School | Protestant | Married | 3 | |
| Elizabeth Davis | 6/6/1905 | 6/6/1905 | New York | New York | Stroke | Female | 58 | High School | Catholic | Married | 2 | |
| William Miller | 7/7/1906 | 7/7/1906 | New York | New York | Pneumonia | Male | 48 | High School | Protestant | Married | 1 | |
| Anna Wilson | 8/8/1907 | 8/8/1907 | New York | New York | Cancer | Female | 52 | High School | Catholic | Married | 2 | |
| Thomas Moore | 9/9/1908 | 9/9/1908 | New York | New York | Heart Disease | Male | 62 | High School | Protestant | Married | 3 | |
| Grace Taylor | 10/10/1909 | 10/10/1909 | New York | New York | Stroke | Female | 56 | High School | Catholic | Married | 2 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
12547
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12520

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | c. LENGTH OF STAY IN 1b <u>1 mo. 5 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u> | | d. STREET ADDRESS <u>Route 2</u> | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>-</u> Last <u>Webster</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 25, 1872</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>-</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>33 IX</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>29 days</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome assoc. with Senile Brain Disease, with psychosis</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-23</u> 19 <u>60</u> , to <u>Nov. 28</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-28</u> 19 <u>60</u> , and that death occurred at <u>11:17</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Harry J. Crawford</u> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Harry J. Crawford</u> | | 22d. ADDRESS <u>Eastern Shore State Hospital, Cambridge, Md</u> | |
| 23a. BURIAL-CREMATATION, REMOVAL (Specify) <u>11/30/60</u> | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR <u>St. Vernon</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Vernon Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Heiman</u> | | 25a. REC'D BY REGISTRAR <u>DEC 5 '60</u> | |
| ADDRESS <u>Princess Anne</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | |

12120

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

12120

1

James E. ...
12120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12530

CERTIFICATE OF DEATH

12521

Reg. Dist. No.

| | | | | |
|---|----------------------------------|---|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | c. LENGTH OF STAY IN IB Life | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mabel Eleanor Bosley Wessels | | 4. DATE OF DEATH Month Day Year Nov. 23, 1960 | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 22, 1916 | |
| 9. AGE (In years last birthday) 44 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Laborer | | |
| 11. BIRTHPLACE (State or foreign country) Cambridge, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Alexander Bosley | | 14. MOTHER'S MAIDEN NAME Julia Ross | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-07-8803 | | |
| 17. INFORMANT Evelyn Wheatley, Cambridge, Md. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 331X DUE TO (c) r PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from November 20, 1960 , to November 23, 1960 , that I last saw the deceased alive on November 23, 1960 , and that death occurred at 8 P M, from the causes and on the date stated above. | | | | |
| ACTUAL SIGNATURE J. Edwin Rosssett, M.D. | | ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. | | |
| DATE SIGNED 11-25-60 | | M.D. | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/26/1960 | | |
| 22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | | 22d. LOCATION (City, town, or county) (State) Cambridge, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Richard M. St. Clair | | ADDRESS Cambridge, Md. | | |
| 24a. REC'D BY REGISTRAR DATE DEC 7 '60 | | 24b. REGISTRAR'S SIGNATURE C. Stuart S. Kraw | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please submit the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

299

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BP

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 12531 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Dorchester, Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland. c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland. d. STREET ADDRESS 112 Mills, Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) William Grason Winterbottom Jr. | | | | | 4. DATE OF DEATH Month Day Year 11 21 19 60 | | | | |
| 5. SEX Male | | | | | 6. COLOR OR RACE White | | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH 12/28/1911 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hardware Business | | | | | 10b. KIND OF BUSINESS OR INDUSTRY Hardware Business | | | | |
| 11. BIRTHPLACE (State or foreign country) Dorchester, Co. Maryland. | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME William Grason Winterbottom | | | | | 14. MOTHER'S MAIDEN NAME Nannie Elizabeth Davis | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. Unknown | | | | |
| 17. INFORMANT William Grason Winterbottom III, Mills, St. | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 22b. DATE THEREOF 11/23/1960. | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Old Trinity Church Yard | | | | | 22d. LOCATION (City, town, or country) (State) Church Creek Maryland. | | | | |
| 23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Maryland. | | | | | 24a. REC'D BY REGISTRAR DEC 9 '60 | | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Hunk | | | | | 24c. DATE SIGNED 11/22/60 | | | | |

1938 MEDICAL EXAMINATION CERTIFICATE OF DEATH

NAME: William Gordon Winthrop
AGE: 48
SEX: Male
DATE OF BIRTH: 1/26/1911
PLACE OF BIRTH: Winthrop, Maine
OCCUPATION: Insurance Business
EDUCATION: High School
RELIGION: Protestant
MARRIAGE: Married
SPOUSE: Mrs. Winthrop
CHILDREN: 3
PREVIOUS ILLNESS: None
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE: [Signature]
DATE: 1/26/1961

1938 MEDICAL EXAMINATION CERTIFICATE OF DEATH